LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
Join the Commission on HIV Email Listserv, Click Here

HIV PREVENTION PLANNING WORKGROUP
Virtual Meeting

Agenda and meeting packet will be available prior to the meeting at http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

Wednesday, February 23, 2022

5:30PM-7:00PM (PST)

JOIN VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
JOIN VIA WEBEX ON YOUR PHONE:

https://tinyurl.com/yckrkf47

1-213-306-3065 US Toll
Access Code: 2597 858 6980
Password: PREVENT

Help prevent the spread of STDs and HIV. Let your voice be heard.

Your input will inform the planning of prevention services in your community.

Follow the Commission on HIV at

Interested in becoming a Commissioner? at **Click here for a Member Application**.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

PREVENTION PLANNING WORKGROUP
Virtual Meeting Agenda

Wednesday, February 23, 2022 @ 5:30 – 7:00pm

To Join by Computer: **https://tinyurl.com/yckrkf47**

To Join by Phone: 1-213-306-3065 US Toll

Access Code: 2597 858 6980

Password: PREVENT

AGENDA

1. **Welcome and Introductions** 5:30-5:45pm
   a. Co-Chair Nominations and Elections

2. Discussion: Continuing our Planning for the Comprehensive HIV Plan (CHP) 5:45-6:15pm
   a. CHP Updates
   b. Define syndemics related to HIV
   c. Discuss strategies to improve mental health services.

3. Review Program Directives from a Prevention Lens 6:15-6:45PM

4. Next Steps and Agenda Development for Next Meeting 6:45-6:50pm

5. Public Comment + Announcements 6:50-7:00pm

6. Adjournment 7:00pm

VIRTUAL MEETING—PREVENTION PLANNING WORKGROUP (PPW)
Wednesday, January 26, 2022 | 5:30-7:00PM
MEETING SUMMARY

Antonio	Kevin Donnelly	AJ King
Dr. William King	Donta Morrison	Katja Nelson
Commission on HIV (COH) Staff: Cheryl Barrit, Carolyn Echols-Watson		
Division of HIV and STD Programs (DHSP) Staff: Shoshanna Nakelsky, Pamela Ogata, Julie Tolentino, Paulina Zamudio		

1. **Welcome and Introductions**

   Kevin Donnelly called the meeting to order at approximately 5:30 PM. Attendees were invited to introduce themselves.

   a. **Co-Chair Nominations and Elections**

   The Prevention Planning Workgroup (PPW) is seeking a co-chair to work alongside Miguel Martinez. Nominations for this position are open.

2. **Discussion: Continuing our Planning for the Comprehensive HIV Plan (CHP) 2022-2026**

   a. **CHP Updates and Feedback**

   - AJ King provided an overview of the Comprehensive HIV Plan (CHP) 2022-2026. Slides can be found in the meeting packet.
   - Key tenets for the CHP include using a status neutral approach, addressing social determinants of health/racial and other inequities, and addressing syndemics.
   - The CHP will build upon local Ending the HIV Epidemic (EHE) Plan and other plans, harness existing and build new partnerships, and focus on community engagement.

   b. **Review of the Ending the HIV Epidemic (EHE) Plan prevention pillar**

   - Pamela Ogata, Division of HIV and STD Programs (DHSP) inquired if the prevention pillar should include prevention activities for other sexually transmitted infections (STIs). Donta Morrison concurred. Paulina Zamudio, DHSP suggested including syphilis and gonorrhea specifically for their connection to HIV. Dr. William King emphasized the importance of STI screenings.
   - W. King expressed interest in learning more about increasing HIV testing programs in non-healthcare setting including home settings. Julie Tolentino, DHSP explained this includes the distribution of HIV self-test kits such as Take Me Home, putting advertisements for HIV test kits on on dating apps, providing test kits to partners such as syringe exchange programs, working with the EHE steering committee, and distributing home test kits at community events. P.

Zamudio discussed testing efforts in locations such as barber shops and churches.

- K. Donnelly discussed California's expansion of HIV and STI testing kits covered under health plans.
- Donta Morrison inquired if progress has been made for rapid at-home STI test kits. P. Zamudio responded that there are rapid test clinics that provide same-day results. DHSP funds three express clinics, two of which are operational.
- K. Donnelly suggested increasing awareness of PrEP, specifically among cisgender women of color.
- K. Donnelly recommended improvement in mental health services.
- A. King asked the PPW if there is sufficient data on PrEP use. P. Zamudio stated that there is not enough data on how many individuals are on PrEP in Los Angeles County. Shoshanna Nakelsky stated that DHSP is working with the state to obtain more data on how many people are using PrEP.
- W. King inquired if DHSP is aware of pharmacies who prescribe PrEP and PEP.
- A. King asked the group if PEP utilization should be included in the CHP. S. Nakelsky stated that the Centers of Excellence and the National HIV Behavioral Surveillance (NHBS) are sources for PEP data.
- K. Donnelly discussed the need for increased prevention efforts among older adults, as this population accounts for 20% of new HIV infections.
- A. King asked the PPW if the following populations should be considered priority populations for the CHO: Black men who have sex with men (MSM), Latinx MSM, cisgender women of color, drug users, transgender individuals, and individuals under 30. The group suggested geography-based targeted services.
- Bridget Gordon commented that surveillance data need racial/ethnic breakdown by gender, transmission category, and age group to better address health disparities.

c. Discuss scientific and policy advances in HIV prevention and strategies

i. The FDA's approval of long-acting injectable biomedical prevention treatments

Cheryl Barrit discussed the FDA's approval of injectable biomedical prevention treatments as another prevention effort strategy.

ii. The CDC's new PrEP guidelines

https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

C. Barrit directed the PPW to the link to the CDC's new PrEP guidelines.

iii. California's expanded requirements to cover the cost of PrEP treatments and at-home STI and HIV test kits

C. Barrit reiterated how California's expanded coverage for PrEP and at-home STI and HIV test kits is important to include for the EHE prevention pillar.

K. Donnelly asked about follow-up for at-home test kits. P. Zamudio responded that referral information is included in the test kits. The DHSP number is also included.

d. Discuss strategies to expand on safe syringe access and address social determinants of health

- K. Donnelly stated that community events are helpful for prevention outreach.

3. Next Steps and Agenda Development for Next Meeting

- The CHP will be a standing item on the PPW agenda.
- C. Barrit will reach out to K. Donnelly and M. Martinez to discuss program directives.
- Discuss strategies to improve mental health services.
- Discuss and further define syndemics related to HIV.

4. Public Comment + Announcements

- There were no announcements.

5. Adjournment

- The meeting adjourned at approximately 6:35 PM.

Quick Reference Handout 5.2: Directives

RWHAP Legislative Requirements

One of the duties of a Ryan White HIV/AIDS program (RWHAP) Part A planning council (PC)* is to

> *"...establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a recipient should consider in allocating funds" [Legislation, Section 2602(b)(4)(C)]*

Directives address *how best to meet* the priorities established by the planning council.

**Planning bodies provide recommendations rather than serving as decision makers, but sound practice is for both PCs and PBs to develop directives.*

Purpose and Focus of Directives

Directives help strengthen the system of care. They provide written guidance to the recipient from the PC/PB regarding how best to meet specific service priorities established as part of the priority setting and resource allocation (PSRA) process, and other factors the recipient should consider in arranging for services. Often, directives address identified barriers to care or disappointing health care system performance on measures and clinical outcomes such as linkage to care, retention in care, adherence to medications, and viral suppression, overall or for particular PLWH populations or geographic areas.

Most directives focus on one or more of the following:

1. **Geographic targeting:** ensuring availability of services in all parts of the EMA/TGA or in a particular county or area

   Examples of directives:
   - *RWHAP-funded outpatient ambulatory health services (HIV-related medical care) must be available within each county in the EMA/TGA, either through facilities located in the county or through other methods such as use of mobile vans or out-stationing of personnel.*
   - *Oral health care must be accessible to PLWH in the EMA/TGA regardless of where they live.*
   - *Mental health and outpatient substance abuse treatment services must be available to PLWH within County X at least 2 days a week.*

2. **Population targeting:** ensuring services appropriate for specific target PLWH populations

   Examples of directives:
   - *Core medical service providers must have bilingual Spanish-English staff in positions with direct client contact, including clinical staff.*
   - *Each of the three counties in the EMA/TGA must have at least one service provider qualified to provide culturally appropriate services to young MSM of color.*
   - *At least one outpatient substance abuse treatment provider must offer services appropriate for and accessible to women, including women who are pregnant or have small children.*

3. **Access to care:** overcoming barriers that reduce access to care

   Examples of directives:
   - *Every funded outpatient ambulatory health services (OAHS) provider and every medical case management provider must offer services at least one evening a week and/or one weekend day a month.*
   - *Transportation must be made available to PLWH who are unwilling to seek care in their own communities due to fear of exposure and stigma, and who require such assistance so they can access care in another location within the EMA or TGA.*
   - *PLWH with a history of unmet need must have access to peer navigator services or other targeted assistance for at least the first six months after they return to care.*

4. **Service models:** requiring the testing or broader use of a particular service model

   Examples of directives:
   - *At least two medical providers will receive funds to test the use of a Rapid Response linkage to care model, designed to ensure that newly diagnosed clients have their first medical visit within 72 hours after receiving a positive test result.*
   - *All medical case management providers will ensure that at least one case manager completes recipient-approved geriatric training on a refined case management model for older PLWH.*
   - *The EMA/TGA will pilot test an Early Intervention Services (EIS) model designed to reach young MSM of color who are newly diagnosed or out of care, link them to care, and help ensure that they become fully connected to medical care.*

Directives are one way of strengthening the system of care. There are other ways, as well, such as adding requirements to universal or service category-specific Service Standards. Sometimes a directive will call for testing a new service model or approach. If it proves successful in addressing the identified need, it may be added to Service Standards and implemented throughout the system of care.

Identifying the Need for a Directive

The PC/PB may identify needs and issues leading to directives at any time of the year through many sources, among them review and discussion of data from the following sources:

- **Needs assessment**—service gaps, barriers to care, or issues identified by consumers, service providers, or PLWH who are out of care, or through a review of epidemiologic data trends
- **Town hall meetings or public hearings** that are part of the PSRA process—identified service needs, gaps, services strengths or weaknesses
- **HIV care continuum**—disparities in linkage to care, retention, and/or viral suppression among specific PLWH populations
- **Service utilization**—disparities in use of particular service categories by different PLWH populations based on such characteristics as race/ethnicity, age, gender/gender identity, sexual orientation, risk factor, or place of residence
- **Clinical Quality Management (CQM)**—identified performance issues or changes in service models that improve patient care, health outcomes, and patient satisfaction

Often, review of such information will help to identify issues such as the following:

- ***Poor service access,*** limited use of services, poor retention, or low rates of viral suppression for PLWH populations, especially those who are traditionally marginalized and/or have co-morbidities
- ***Lack of culturally and linguistically appropriate services*** overall or in particular locations or specific service categories
- ***Too few providers in outlying areas*** of the EMA or TGA
- ***A need for new models or strategies*** to better address the changing local epidemic

HRSA/HAB Expectations

PC/PBs have a great deal of flexibility in the development and use of directives. Directives can be developed whenever available data indicate the need for action to provide parity in access to high quality care for all PLWH, regardless of who they are or where they live within the service area.

HRSA/HAB expects directives to be:

- **Based on an identified need,** determined through review of data from needs assessment, town hall or other community meetings, service utilization data, CQM activities, or other sources
- **Explored and developed as needed throughout the year**—often with the involvement of several committees, such as the following (Committee structures and names vary by jurisdiction):
  - *Needs Assessment and Planning*
  - *Care Strategy/System of Care*
  - *Consumer/Community Access*
  - *Priority Setting and Resource Allocation*
- **Presented in relation to the PSRA process,** since they often have financial implications and may require changes in how services are delivered—and are best addressed through discussion with the recipient before allocations have been made
- **Approved by the full PC/PB,** along with or separate from resource allocation
- **Consistent with an open procurement process.** Directives should not have the effect of limiting open procurement by making only 1-2 providers eligible, since the PC/PB should have no involvement in the selection of specific entities to serve as subrecipients.

  For example, consider the following possible directives:

  > *Mental health services must be provided by clinicians that can demonstrate expertise in serving people living with HIV*
  >
  > *Mental health services must be provided by organizations with prior RWHAP experience*

  The first is an acceptable directive, requiring that mental health clinicians have appropriate expertise to serve PLWH—which can be obtained through training and/or prior experience, regardless of funding source. The second suggested directive is not acceptable, because it limits possible subrecipients to those that have received RWHAP funding in the past. There might be only one or two entities that meet that requirement, which would prevent an open procurement process.

Tips for Preparing Sound Directives

The following approaches support the development of sound directives:

1. **Provide a limited number of carefully thought-out directives.** If the PC/PB proposes too many directives, they may not receive the individual attention or resources needed for successful implementation.
2. **Review current directives,** to retire those that no longer apply and to avoid duplication where appropriate by refining an existing directive rather than developing a new one. Directives only rarely need to be maintained over many years. If the approach in the directive proves effective, it can be made permanent through other means, such as inclusion in Service Standards.
3. **Base directives on data and be prepared to present the underlying data** when proposing a new or revised directive to the PC/PB.
4. **Identify and research possible directives throughout the year,** as part of your ongoing efforts to improve the continuum of care. This provides time to explore service models used by other jurisdictions, determine costs, and have a well-considered directive to present as part of PSRA —and ensure allocation of resources needed for implementation.
5. **Refer to but don't duplicate requirements in existing Service Standards.** If aggregate monitoring or CQM data show that Service Standards are not being met, the PC/PB should explore with the recipient why this is happening—and may want to consider a directive that offers a refined approach.
6. **Use plain, direct language** so that the directive is easy to understand and implement.

Role of the Recipient

The recipient is *responsible for implementing* directives. Beyond that, the PC/PB should collaborate with the recipient as it formulates directives, particularly with regard to assessing the costs, feasibility, and timing of implementing a potential directive.

COSTS

Suppose the PC/PB has developed the following proposed directive to improve retention in care for employed PLWH:

> *All RWHAP Part A-funded OAHS and medical case management providers must provide services at least one evening a week or one weekend day a month .*

Adding evening or weekend hours may improve care, access and retention, but it also adds costs for staff and for keeping the facility open longer. Before time for resource allocation, the PC/PB needs to ask the recipient to estimate the added costs per year for evening hours and for weekend hours. That will allow the PC/PB to refine the directive if necessary. For example, if it would be much less expensive to use evening rather than weekend hours, it might remove the weekend option. That will also give the PC/PB the information needed to add dollars to the OAHS and medical case management allocation to permit implementation of this directive—unless it is willing to serve fewer PLWH in these service categories.

FEASIBILITY

The PC/PB should consult with the recipient regarding such issues as whether a similar strategy or service model has been tried before, and if so, with what results; and whether the directive can be implemented or perhaps needs to be revised or restated. For example, a directive that calls for use of telemedicine in providing mental health services is feasible only if state law allows such use of telemedicine. Strategies must be

consistent with RWHAP service definitions and other HHS guidance. Incentives for keeping medical appointments must meet federal guidelines or be funded out of non-federal funds.

TIMING

It is not always possible for a directive to be implemented quickly. While some jurisdictions may be able to modify the scope of work for a multi-year subrecipient contract, others will not be able to change requirements or specify a new service model until the service category goes out for competitive bid, which may happen only every 2-4 years. It is sometimes possible to state a directive so that parts can be implemented immediately. For example, the directive below will probably be implemented only after these service categories go out for bid, since it is likely to require hiring of staff with specific skills and experience:

> *All OAHS and medical case management providers must ensure transgender PLWH and African immigrants receive services only from clinicians and case managers with both training and experience in serving these populations.*

As an interim measure, the following directive could be implemented quickly, with assistance from the recipient, or the PC/PB could instead decide to add it as a requirement in its Service Standards:

> *All OAHS and medical case management staff serving transgender PLWH and African immigrants must first complete in-depth, recipient-approved cultural competence training to prepare them to serve these populations.*

Discussion with the recipient can help in addressing these cost, feasibility and timing challenges.

Assessing Implementation and Results

Directives are generally implemented by the recipient through procurement and contracting, and/or program monitoring and clinical quality management (CQM) efforts, including quality improvement projects. The recipient must follow directives in procurement and contracting but cannot always guarantee full success. For example, the recipient might put out a request for proposals (RFP) to implement a new service model but receive no qualified responses. The recipient may want to suggest revisions in the directive to make responses more likely.

Once a directive has become a requirement for subrecipients, its implementation can be followed through program monitoring, reviewed as part of CQM, or assessed in terms of changes in performance measures or clinical outcomes for affected PLWH. The recipient should always be asked to provide updates on implementation of directives, ideally at least quarterly. The PC/PB and recipient should work together to assess the results of directives and to decide when a pilot project should be expanded, refined, or ended.

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816
FAX (213) 637-4748 • HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

October 9, 2020

To: Mario J. Perez, Director of HIV and STD Programs (DHSP), Department of Public Health

From: Alvaro Ballesteros and Bridget Gordon, Co-Chairs, Commission on HIV

Re: Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32

In keeping with the Commission on HIV's commitment to engage in multi-year priority setting and resource allocation planning for the next three years, the PP&A Committee has developed a set of program directives for program years (PY) 30, 31, and 32. The multi-year service rankings and allocations aim to assist DHSP in your programmatic planning and initiating the solicitations process so that services are in place by the start of the upcoming Ryan White program years.

Part A Planning Councils are required to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a Recipient should consider in allocating funds under a grant based on numerous factors including: "size and demographics of the population of individuals with HIV disease;" "priorities of the communities with HIV disease;" and "capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities."

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)
This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure

alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

Based on epidemiological data, the disproportionately impacted populations in Los Angeles County are **young MSM (YMSM), African American MSM, Latino MSM, and transgender persons**. Given the physiologic role that sexually transmitted diseases (STDs) play in HIV transmission, it is recognized that maximizing HIV prevention will require significant reduction in syphilis and gonorrhea cases, among these aforementioned groups and **women of color** (LACHAS, pg. 14).

The 2019 HIV Surveillance Report notes following areas of disparities:

- Largest gaps in awareness of HIV-positive status existed for persons aged <35 years, where over 50% of HIV-infected persons aged 13-24 years and one third of HIV-infected persons aged 25-34 years were unaware of their infection. Disparities also existed for persons who inject drugs (PWID), with over one-third of HIV-infected PWID unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

- There are continued disparities in HIV diagnosis by population and geographic location. Rates of new HIV diagnosis are higher among men than women. Across age groups, young men aged 20-29 years and women aged 30- 39 years had highest HIV diagnosis rates. Black men and women had higher rates of HIV diagnosis compared with other race/ethnicity groups. Among men the highest rates of diagnoses were seen in the Central, South, and Hollywood-Wilshire Health Districts, and the highest rates for women were seen in the Central, South, and Southeast Health Districts.

- Populations with lowest achievements in linkage to care were females, Blacks, adolescents, persons aged ≥ 60 years, and persons with injection drug use (IDU) or heterosexual transmission risk. Health Districts with greatest need for interventions to improve linkage to HIV care services were Antelope Valley, El Monte, and South Health Districts where linkage rates were ≤ 70%.

- Approximately 9 in 10 people living with diagnosed HIV were on HIV treatment. Of those, 8 in 10 had adhered to their drugs in the past 3 days. Treatment coverage was lowest for Black populations and persons aged < 40 years, while adherence was lowest for younger persons aged <30 years and the Latinx population.

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income

and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWH. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

It is important to note that during the Committee's service ranking deliberations, the consumers, ranked housing as their number one service need for PY 31 and 32. This speaks to the need for keeping PLWH stably housed to support their retention to care, viral suppression and overall health. Medical/outpatient care also remains a top priority for consumers.

The program directives below expand on the directives sent to DHSP on April 23, 2019:

1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

    - Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.
    - In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.
    - Assess available resources by health districts by order of high prevalence areas.
    - Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.
    - Fund mental health services for Black/African American women that are responsive to their needs and strengths.
    - Ear mark funds for peer support and psychosocial services for Black gay and bisexual men.
    - It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.

3. Provide Non-Medical Case Management services in non-traditional and traditional

locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults.[1]

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.

6. Continue to support the expansion of medical transportation services.

7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distribution of eligibility cards as stated by DHSP representatives.

8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children.

   Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.

9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.

10. Fund psychosocial services and support groups for women. Psychosocial support services must

[1] The Aging Task Force will provide further guidance on the age parameters for "older adults."

include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

In order to inform the Commission's planning efforts around HIV/STD prevention and care services, we direct DHSP to provide written fiscal reports and status updates on these directives to the PP&A Committee and full Commission on a regular basis.

In support of the recommendations from the PP&A Committee, Standards and Best Practices (SBP) will continue updating and/or developing service standards for the following service categories. These service categories were prioritized by the PP&A Committee as recommended by DHSP and because of the feasibility of releasing solicitations in 2020-2022. Status updates on the development of service standards are noted below.

1. **Universal Service Standards -**Completed; updated and approved on 9/12/19
2. **Non-Medical Case Management –** Completed; updated and approved on December 12, 2019
3. **Psychosocial Support -**in progress and on the 9/10/20 Commission agenda for approval
4. **Emergency Financial Assistance –** Completed; approved by the Commission on 6/11/20
5. **Childcare** - in progress; public comment period 9/11-9/23; target month for Commission approval is October/November

The Commission is committed to ongoing collaborations with DHSP and we seek your feedback on how we can work together to implement these directives. We thank DHSP for ongoing regular progress reports on implementing directives and efforts to maximize Ryan White funds and activities to end the HIV epidemic. Furthermore, we appreciate feedback from DHSP in updating service standards. Thank you, we appreciate the ongoing partnership and support from you and your staff.

cc: Raquel Cataldo, PP&A Co-Chair
Kevin Stalter and Erika Davies, SBP Committee Co-Chairs
Miguel Martinez and Jason Brown, 2019 PP&A Committee Co-Chairs

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

(REVISED) Black/African American Community (BAAC) Task Force Recommendations

October 10, 2019

Introduction

The BAAC Task Force was formed in response to the Commission on HIV's (COH) February 14, 2019 National Black HIV/AIDS Awareness Day (NBHAAD) Panel discussion in an effort to address the disproportionate impact of HIV/AIDS in the Black/African American (AA) communities of Los Angeles County.

The BAAC Task Force convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the COH on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs in all subsets of the Black/AA community utilizing a community-wide mobilization effort.

Healthcare Disparities in the Black/AA Community

The United States Census Bureau estimates Black/AA living in Los Angeles County (LAC) at 9% or approximately 909,500 as of 2018.(1) In 2017, there were 51,438 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) were Black/AA.**(2)

In 2016, **the highest overall rate of HIV diagnoses was among African Americans (56 per 100,000)**, followed by Latinos (19 per 100,000), whites (12 per 100,000), and Asians (6 per 100,000). These differences in rates were also observed by sex, most notably among **African American females (17 per 100,000) where the rate of HIV diagnoses** was 8 times higher than that of white females (2 per 100,000) and 5 times higher than the rate for Latinas (3 per 100,000). Among **males**, the rate of HIV diagnoses among **African Americans (101 per 100,000)** was 5 times higher than among whites (22 per 100,000) and 3 times higher than the rate for Latinos (34 per 100,000).(2)

The highest rate of stage 3 diagnoses (Acquired Immunodeficiency Syndrome) (AIDS) **was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).(2)

Black/AA Care Continuum as of 2016[3]

Demographic Characteristics	Diagnosed/Living with HIV	Linked to Care ≤30 days	Engaged in Care	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
Race/Ethnicity						
African American	**9,962**	**54.2%**	**65.9%**	**49.7%**	**50.3%**	**53.0%**
Latino	21,095	65.4%	68.3%	55.7%	44.3%	59.7%
Asian/Pacific Islander	1,710	80.5%	74.6%	60.5%	39.5%	68.5%
American Indian/Alaskan Native	294	75.0%	70.1%	54.10%	45.9%	52.4%
White	14,778	75.2%	71.6%	54.5%	45.5%	64.9%

The Ryan White (RW) program in LAC served 15,747 individuals between March 1, 2018 and February 28, 2019. Three-thousand three-hundred sixty (3,360) were Black/AA during the same period.[4]

Objectives:

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders in an effort to end HIV in the Black/AA community
- **Identify** HIV prevention, care and treatment best practices in the Black/AA community
- **Identify** specific strategies to reduce HIV stigma in the Black/AA community

General/Overall Recommendations:

1. Provide on-site cultural sensitivity and education training – to include addressing implicit bias and medical mistrust within the Black/AA community – for all County-contracted providers and adopt cultural humility into the local HIV provider framework. *Decision makers must realize their own power, privilege and prejudices and be willing to accept that acquired education and credentials alone are insufficient to address the HIV epidemic in the Black/AA community.*

2. Revise messaging County-wide around HIV to be more inclusive, i.e., "If you engage in sexual activity . . . you're at risk of HIV" in an effort to reduce stigma.

3. Incorporate universal marketing strategies for HIV prevention that appeal to all subsets of the Black/AA community in an effort to reduce stigma and increase awareness.

4. Provide resources to Community-Based Organizations (CBOs) to develop, implement and evaluate primary prevention interventions which are culturally appropriate and relevant.

5. Support young people's right to the provision of confidential sexual health care services.

6. Increase Pre-exposure Prophylaxis (PrEP) advertising within the Black/AA community to increase awareness. Marketing materials must depict the very community it is attempting to reach - specifically, Black/AA youth, women, transgender individuals, and gender nonconforming populations.

7. Initiate or partner in culturally informed research that aims to address the needs of the Black/AA communities. Researchers, whenever possible, must mirror the affected community it purports to study. Community reflectiveness in academic and CBO partnerships should include training in instrument development, data interpretation, presentations and publications.

8. Increase use of local statistics regarding new infections and disparities to educate and plan for the community; request Department of Public Health data be organized by Health Districts and zip codes to better target and identify communities in need.

9. Provide technical assistance to aid Black/AA agencies in obtaining funds for culturally sensitive services.

10. Proactively reach out to engage CBOs that are connected to the local Black/AA community.

11. End the practice of releasing Request for Proposals (RFPs) that have narrowly defined "Proposer's Minimum Mandatory Requirements." *This discriminatory practice purposely disqualifies existing relevant CBOs and other agencies that provide intersection health and human services.* When issuing RFAs, RFPs, or RFSQs, establish a demonstration/data pilot by creating a 15% funding carve-out for CBO's/ASO's, whose qualifications are below the "Minimum Mandatory Requirements", but at an agreed upon standard, to identify the proven and effective grassroots/community empowerment efforts that reach specified Black/AA audiences. This will allow DHSP in collaboration with the Commission to determine the efficacy of methodologies for outreach, linkages to care, retention in care, and other sensitive treatment and prevention interventions that are effective in reducing new HIV cases.

12. Continue to evaluate for effectiveness and increase the investment in Vulnerable Populations Grants that target subset populations of the Black/AA community (i.e. Trans men/women, women & girls, MSM) to address barriers and social determinates of health.

13. Engage agencies already funded as well as those not currently funded to focus on a Countywide PrEP Education and Outreach mini-grant process that will target all various subset populations of the Black/AA community, i.e. Trans community, women & girls, MSM.

14. Increase mobilization of community efforts to include:
    a. Increase community awareness fairs and social media campaigns intended to promote health and wellness in the Black/AA community, with concentration in high incidence areas;
    b. Condom distribution in spaces where adults congregate;
    c. HIV education and access to prevention tools in schools, spiritual communities, social clubs, neighborhood associations, etc.;
    d. Fund one social marketing campaign that addresses stigma and internalized homophobia as it relates to health and wellness around HIV;
    e. Support efforts that will ensure additional research and evaluation support be made available to agencies that provide services to the Black/AA community and to increase their capacity to link and collaborate with research institutions; and
    f. Provide training and incentives for CBOs within high incidence areas to prescribe PreP and nPep.

Population-Specific Recommendations:

Black/African American Trans Men:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans masculine community that focuses on sexual risk behaviors.
2. Use Williams Institutes' research/data using Sexual Orientation Gender identity (SOGI) (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans male-specific programming.
3. Include Trans men in program decision making.
4. Develop a Trans masculine-specific PrEP campaign which will resonate with and reach Trans men in such a way that the message is not convoluted and therefore lost within the overall PrEP messaging. Messaging should include language around safety and gender affirmation - a campaign that says "Trans masculine individuals . . . this is for YOU." Perhaps include a myth buster around the notion that all Trans men are straight and only date and are sexually involved with cis men; a message that says we know sexual appetites are fluid for Trans men and that is why PrEP is important.
5. Educate/train medical and mental health providers to be more inclusive of Trans masculine bodies and its many different nuances.

6. Create a pilot/demonstration project using the information obtained from the various data sources listed above.

Black/African American Trans Women:

The Ryan White (RW) program in LAC served 96 Black/AA Transgender persons during the period of March 1, 2018 to February 28, 2019. This was approximately .6% of the total PLWH/A in LAC.(4)

1. Conduct a Countywide needs assessment of the Trans women community to address barriers and social determinants of health to better provide more targeted programming.
2. Increase efforts in collecting epidemiological data through surveillance on Trans women for purposes of planning more targeted programming.
3. Use William's Institutes' research/data using SOGI (method agencies use to collect patient/client data on sexual orientation and gender identity) to develop Trans women-specific programming.
4. Include and prioritize Trans women in program decision making.
5. Address stigma and the increasing violence against Trans women.

Black/African American Women and Girls: *(DHSP defined Black/AA women and girls as either childbearing women between the ages of 15-44 and those 50 Years and Older)*

The Ryan White (RW) program in LAC served 501 Black/AA women during the period of March 1, 2018 to February 28, 2019. This is approximately 31.82% of those receiving RW services.(4)

1. Evaluate existing PrEP and prevention access and messaging for impact on intervention groups and community health; assess dissemination methodologies and refine outreach and engagement strategies.
2. Allocate resources to create a PrEP Center for Excellence targeting women and their families, sexual and social networks.
3. Conduct an inventory of County-wide HIV/STD interventions and initiatives that target African American women at risk of and living with HIV that focus on education, employment services, empowerment, co-infections, treatment as prevention (TAsP), sexual reproductive health, intimate partner violence, and mental health.
4. Obtain data for all populations of women, especially those who are pregnant or such age groups affected by the high rates of STIs; include women-specific data in summits, reports, and community forums.

5. Reorganize and adopt educational approaches to care and prevention that incorporate information and knowledge on how preventative methods can benefit the woman within the context of her life. Such approaches include but should not be limited to:
   a. Integrate train-the-trainer models for community health outreach workers and testing staff that use motivational and empowerment strategies as a tool for risk reduction. Generating collective approaches and solutions that promote honesty and integrity within self and relationships with others is paramount. Hold agencies accountable to host honest adult conversations and have the courage to meet people where they are and build on what they know.
   b. Generate collective approaches and solutions that promote honesty and integrity of self and relationships with others is paramount; and
   c. Train community health outreach workers in all HIV Testing Sites to have conversations that validate the experience and power dynamics women confront within their relationships. Most often partners are missing from engagement, enrollment, and retention strategies. Include sexual and social networks in education, outreach, testing and other interventions that support family sustainability as a method of retention.

6. Allocate money to partner with institutions to support three demonstration projects at $250,000 each led and facilitated by and for Black women:
   a. Ensure agencies have tools available to demonstrate accountability and cultural competence. Staff should be linguistically and culturally representatives of the community and any intervention include a navigation component to address barriers to recruitment, uptake and retention of prevention and care based programming.
   b. All protocols should explicitly embrace the experience of women who have sex with men of known or unknown status as well as those diagnosed with HIV/AIDS. Further, qualitative interviews or Audio Computer-Assisted Self-Interview (ACASI) instruments should include an assessment of historical care and prevention participation as well as barriers to continuous engagement and participation.

7. Strategically reflect the needs of women in the jurisdictional stigma reduction efforts by funding projects that reduce stigma and increase access to female controlled HIV preventive tools such as Pre-Exposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP), and the Female Condom 2 (FC2). Support agencies to integrate comprehensive opportunities for education, research and a complement to other strategies that give women the power to take control of their lives and situations in which have historically had little to no influence.

8. Expand the availability of community-based mental health services as a part of a continuous effort to treat women holistically: HIV and mental health education and awareness should accompany a range of holistic services that recognize that a woman may have multiple traumas that inform her choices. Increased collaborations between community and the private sector which is necessary to build awareness and reduce cultural and social based stigmas associated with mental health care. Increased education and training of non-HIV/AIDS service providers in hopes of offering a full circle of multidisciplinary services to those in need.

9. Develop a standard requiring all contracted organizations offer living wages as an incentive to hiring persons with lived experience. Initiating programming for Black women enables organizations to invest in their peers. Further, increased access to professional development opportunities and resources (ex. Income) enables them to self-sustain and decrease the impact that social correlates of health such as poverty have on informed sexual decision making.

<u>Black/African American Men Who Have Sex with Men (MSM):</u>

The Ryan White (RW) program in LAC served 2,093 Black/AA MSM during the period of March 1, 2018 to February 28, 2019. This was approximately 13.3% of those receiving RW services. (4)

1. Continue to increase the investment in innovative layered interventions that target young MSM and address barriers and social determinates of health like the Vulnerable Populations Grant.

2. Develop and release of Request for Application/Request for Proposal (RFA/RFP) that focuses on HIV positive MSM of all ages who are sexually active and at risk of co-infections.

3. Increase funding and resources in treatment as prevention, social support efforts, housing and mental health services.

4. Address Chemsex within the Black/AA MSM community through CBO led group sessions, evidence-based medicine directed intervention and medication assisted treatment.

Conclusion

Only by genuinely addressing the recommendations as provided above can the Los Angeles County HIV/AID Strategy (LACHAS) goals be met. Many of the recommendations provided are in alignment with the LACHAS and the County's Comprehensive HIV Plan (CHP), however, there must be very intentional and targeted efforts made to address social determinants, primarily stigma and racism, in the Black/AA communities. It is not enough to implore the same strategies of old; we must modernize methodologies in our marketing strategies to reach subpopulations within the Black/AA communities who do not identify according to current messaging. Messaging must be *truly* inclusive – "if you are sexually active, you are at risk".

The adage is true – "to reach them, you have to meet them where they are" - HIV and sexual health education along with HIV prevention interventions must be accessible in schools, jails, churches, barber/beauty shops, and social venues where Black/AA communities gather; while providers must be trained and educated to understand the various cultural nuances that can either stigmatize and subsequently discourage or create a culturally welcoming environment for Black/AA communities to access HIV prevention, care and treatment services.

On behalf of the BAAC Task Force, we thank the Executive Committee for its consideration of the above recommendations and look forward to its plan of action in response.

Special thanks to the following BAAC Task Force members and community stakeholders who volunteered their time and contributed to the development of recommendations: Greg Wilson (COH), Traci Bivens-Davis (COH), Bridget Gordon (COH), Dr. LaShonda Spencer (COH), Danielle Campbell (COH), Yolanda Sumpter (COH), Dr. William King (COH), Cynthia Davis (AHF), Luckie Fuller (COH), Jeffrey King (ITMT), Louis Smith III, Stevie Cole, Ivan Daniel III, Carl Highshaw (AMAAD Institute), Charles McWells (LACADA), Dr. Derrick Butler (THE Clinic), David Lee (CDU), Rev Russell Thornhill (MAPP), Terry Smith (APLA), Doris Reed (COH), Carolyn Echols-Watson (COH) and Dawn Mc Clendon (COH).

Endnotes

1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19) Los Angeles County; Utilization by Service Category among Ryan White Priority Populations in Year 28

Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32
Status Updates from the Division of HIV and STD Programs (DHSP)

DIRECTIVE	DHSP RESPONSE/STATUS UPDATE
1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.	Solicitations are composed using the latest data, which reflect the geography and other demographics of target populations
2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:	
• Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.	In progress. Some training resources still need to be identified and tested.
• In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/AfricanAmerican population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.	This should be included in the needs assessments conducted as part of the formative work for the development of the comprehensive plan.
• Assess available resources by health districts by order of high prevalence areas.	
• Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.	
• Fund mental health services for Black/African American women that are responsive to their needs and strengths.	Is there a different standard of care for these services for this population?

• Earmark funds for peer support and psychosocial services for Black gay and bisexual men. • It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.	Must be allocated by PP&A. DHSP relies on SBP for guidance.
3. Provide Non-Medical Case Management services in non-traditional and traditional locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults (over 50 yrs).	Commission must allocate funds for these programs.
4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.	DHSP has used EHE and HRSA CARES funds to improve capacity to store perishable, nutritious foods, and increase variety and quality of food available consistently.
5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.	The entire housing portfolio needs to be examined in order to determine where DHSP's limited housing resources can have the most impact.
6. Continue to support the expansion of medical transportation services.	In progress
7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to	In progress

reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distributionof eligibility cards as stated by DHSP representatives.	
8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children. Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM andtransgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.	Childcare solicitation is nearly complete. EFA program is in place.
9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.	Need more information on what this would look like.
10. Fund psychosocial services and support groups for women. Psychosocial support services must include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.	Commission should allocate funds accordingly.